Gonococcal Conjunctivitis Of the Newborn

To the Editor: Recently a correspondent asked what has happened to gonococcal conjunctivitis of the newborn [Shaw EB: Gonorrhea and ophthalmia prophylaxis (Letter to Editor). Calif Med 112:98, Mar 1970]. Of 20,000 live births (excluding sections) at the Los Angeles County-University of Southern California Medical Center during two years, 1968-69, 13 developed gonococcal conjunctivitis; 10 of these infants had low birth weights. This infection rate of 6 per 10,000 live births is the same as was noted here (Amer J Obstet Gynec 73:805-807, 1957) for the period of ten years 1946-56. During both of the above intervals prophylaxis with 1 percent silver nitrate was routinely used. The number of infections per year ranged from zero to 11. Various reviews of the problem (Acta Ophthal 43: Supp 79, 1-70, 1965) have noted that the efficacy of silver nitrate or antibiotic prophylaxis still has not been adequately evaluated. The problem of prophylaxis cannot be studied in states such as California where prophylactic use of 1 percent silver nitrate or penicillin ophthalmic ointment in both eyes is compulsory within two hours after birth.

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Definition of Health

To the Editor: The fellow who wrote that World Health Organization definition of health* which was included in one of your April editorials must not have been a practicing physician. Is anybody ever in that state as defined? Certainly nobody I know.

The definition I like is the one given by John Morgan in his book printed in 1765, *A Discourse Upon the Institution of Medical Schools in America:* "Health is that choice seasoning which gives a relish to all our enjoyments."

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"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (Cited *in* On a definition of health. Calif Med 112:63-64, Apr 1970.)

Relate "Relevance" to Problems

To the Editor: Having accepted "Relevance in Medical Education" as a desirable goal, we are in danger of degrading a useful slogan into a worn cliché and debating it to death. [See issues January through June 1970.] I suggest we have heard a sufficiency of generalities on the subject and had best move on to define *specific* problems and experiment with possible solutions.

"Relevant" topics for exploration in the post-cliché state of inquiry might be:

1. What specific skills now reserved to physicians could be readily learned and applied by others? (A dental study has shown that six weeks' training suffices for a person with high school background to fill cavities as expertly as a dentist.)

2. Which *specific* procedures must be carried out by the physician to maintain the doctor-patient relationship required by our culture? (Must lumbar punctures, minor surgical procedures, physical examination, history taking always be performed by a physician?)

3. In what specific instances is maintenance of the traditional doctor-patient relationship crucial, in what instances must it be improved, in what instances can it be abandoned? (Mass treatment of yaws, malaria, hookworm can be highly effective in many settings with very little emotional contact.)

4. Given the limited willingness of society to pay for optimal individual care for everyone at today's prices, how can we make the necessary specific choices? (How shall we decide whether to buy a transplant giving one person with kidney failure an extra year of life or N treatments giving 50 patients a lifetime alleviation of a more tractable physical or mental disability or to better care of the newborn to insure his seventy year life expectancy.)

5. Which *specific* and presently available methods are most effective in inducing self-learning and in exploiting the student's high motivation when he enters medical school? (Human nature *can* be changed. An old tradition made it our

"nature" to see things white as good and black as bad yesterday. A new tradition has made many of us see black as beautiful today.)

These are only random examples of well known questions, which could be answered by an equally well known method: Scientific experiment.

Unfortunately, the temptation to engage in easy moralizing is often irresistible — as this letter proves once more. Can we all resolve to publish data rather than exhortations the next time around?

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A Way to Make More Medical "Schools"

To the Editor: No expansion short of doubling our medical schools' graduating classes is going to do more than maintain the present physician-population ratio. Even the most optimistic realize that by using the customary channels—larger grants, larger classes, larger physical plants, new medical schools, larger faculties, etc., there can be no net gain in the supply of doctors in less than ten years.

There is, however, a relatively simple way that would provide immediate relief to some overworked doctors, an absolute doubling of physician graduates in four years, besides better trained graduates.

Simply realize and capitalize on the fact that there are as many practicing physicians and/or hospital staffs as there are medical students who could give students adequate clinical teaching and experience away from the confines of medical schools.

We could begin the regular number of freshman medical students this fall. After six months of classroom work, preceptorship them out to carefully screened active doctors' offices, medical groups, and/or hospital staffs for six months, and admit a second freshman class of equal numbers.

By thus alternating six months of classroom work with six months of high quality on-the-job-training throughout the four years, not only would these graduates be as well or better equipped for practice, but they would also have helped ease the doctor shortage from their first year of medical school.

The stage is ripe for legal licensing of a new level of physician assistants. Certainly there could be no better physician assistants than medical students advancing in training and responsibility under legal licensure throughout their medical course.

Besides the actual valuable experience of studying and helping with a busy private practice, staff meetings, teaching rounds, pertinent lectures, etc., are available to the preceptee in every medical community.

Still another plus is the fact that the student as a salaried physician assistant could defray at least a part of the medical school expenses. This would automatically open the way for more medical student prospects from the lower income levels.

It would be understandably difficult for deans and curriculum planners to see the full merit of an educational plan so drastically different from what they have painstakingly and skillfully evolved over the years. Therefore, to institute this or any other radical change, the ball probably will initially have to be picked up and carried by those not at present directly involved with medical school curriculum planning.

If this is not a feasible plan or if there are better alternative ways of immediately doubling our medical school enrollment, let's hear it.

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Costly Mythology In Health Care

To the Editor: Your article *Costly Mythology in Health Care* [(Editorial). Calif Med 112:81-82 Mar 1970] has the one salutary effect of making one think about your statements.

You label as a myth the fact that "Scientific medicine can bring good health if it is readily available and used correctly." That fact must be questioned and corrected.

Scientific medicine has brought good health where it has been properly applied. Especially noteworthy are the areas of Preventive Medicine: